DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/03/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
					R		
15K116			B. WING _	B. WING			17/2013
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE		
COMFORCARE HOME HEALTH				1	1555 NORTH MERIDIAN STREET, SUITE 100		
OOMI OIK	PARE HOME HEALTH			C	CARMEL, IN 46032		
(X4) ID	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID		PROVIDER'S PLAN OF CORRECTION		
			PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
IAG REGULATORY OF		100 IDENTIFY THE INFORMATION	IAG		DEFICIENCY)		
{G 000}	{G 000} INITIAL COMMENTS		{G 0	00}			
(0 000)	NATIVE COMMENTO			ردد			
	This was a revisit for	a federal home health initial					
		hich resulted in an extended					
	survey on 10/31/13.	mon resulted in an extended					
	Facility provider number	ber: 013284					
	0 11 5 1	47.0040					
	Survey date: December 17, 2013 Medicaid vender number: Pending Surveyor: Bridget Boston, RN, Public Health						
	Nurse Surveyor						
	Census: 7 Clinical record review: 3						
	During this survey, it	was determined two					
		standard level deficiencies					
	were corrected and the	rree standard level					
	deficiencies were rec	ited.					
	Camplana a antinua	and the least representation of the second					
		es to be precluded from					
		ne health aide training and on program for a period of 2					
		ember 12, 2013, through					
		due to being found out of					
		Conditions of Participation 42					
		lealth Aide services and					
		sive Assessment of Patients.					
	r						
		e Elder, MSN, BSN, RN					
	December 2	0, 2013					
	This survey was mod	ified 1/3/14 as the result of a					
	QA review. je						
{G 211}	•	TENCY EVALUATION &	{G 2	11}			
, ,				,			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER COMFORCARE HOME HEALTH			11	TREET ADDRESS, CITY, STATE, ZIP CODE 1555 NORTH MERIDIAN STREET, SUITE 100 CARMEL, IN 46032			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{G 211}			{G 2	211}			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

erformance of all care 11/29/13, byee E provided 13, and December visits the aide monitoring. employee A	B. WING _ ID PREFI) TAG	STREET ADDRESS, CITY, STATE, ZIP CODE 11555 NORTH MERIDIAN STREET, SUITE CARMEL, IN 46032 PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION (X5) SHOULD BE COMPLETION
erformance of all care 11/29/13, byee E provided 13, and December visits the aide monitoring.	PREFI) TAG	11555 NORTH MERIDIAN STREET, SUITE CARMEL, IN 46032 PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	E 100 RECTION (X5) SHOULD BE COMPLETION
erformance of all care 11/29/13, byee E provided 13, and December visits the aide monitoring.	PREFI) TAG	IX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDITIONAL DEFICIENCY)	SHOULD BE COMPLETION
care 11/29/13, byee E provided 13, and December visits the aide nonitoring.	{G 2	211}	
ne entire e completed before d in patient's			
4. The policy titled "Quality Management - Nursing Aide / HHA" stated, "All aide services are provided in accordance with the recognized state regulations Aide Training. The aide must pass a HHA [home health aide] competency exam and a registered nurse will complete a competency assessment skills checklist with direct observation of each skill for each aide before assignment begins." 484.36(b)(1) COMPETENCY EVALUATION & IN-SERVICE TRAI The HHA is responsible for ensuring that the individuals who furnish home health aide services on its behalf meet the competency evaluation requirements of this section. This STANDARD is not met as evidenced by:		212}	
regulations Aide Training. The aide must pass a HHA [home health aide] competency exam and a registered nurse will complete a competency assessment skills checklist with direct observation of each skill for each aide before assignment begins." 484.36(b)(1) COMPETENCY EVALUATION & IN-SERVICE TRAI The HHA is responsible for ensuring that the individuals who furnish home health aide services on its behalf meet the competency evaluation requirements of this section.		re recognized state The aide must The aide must competency will complete a checklist with for each aide EVALUATION & {G 2} Suring that the health aide services ency evaluation se evidenced by: real record, and re agency failed to met the	re recognized state The aide must competency will complete a checklist with for each aide EVALUATION & G 212} Suring that the health aide services ency evaluation se evidenced by: hal record, and he agency failed to met the

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X2) PROVIDER/SUPPLIER/CLIA (X2) IDENTIFICATION NUMBER: A. BU		PLE CONSTRUCTION IG	· /	(X3) DATE SURVEY COMPLETED	
		15K116	B. WING _			R 12/17/2013	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 11555 NORTH MERIDIAN STREET, SUITE CARMEL, IN 46032	.100		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
{G 212}	aide file reviewed, the employed, creating the current patient that reservices. The findings include: 1. Personnel file E elebeen hired on 8/12/1 aide services on behincluded an incomplet that was dated 8/12/1 competency docume 8/12/13 and evidence evaluated by the new 12/4/13: 1) Evaluatio and passive of upper active and passive, 2 chair, 3) A bed bath, a bed, 6) Blood press respirations, and puls Reporting patient chaemergencies and proevaluated for the conskills. 2. Clinical record # 5 included documentat services on Novemble 6 and 11, 2013. Duri	1 (file E) of 1 home health aide only home health aide he potential to affect the one eccived home health aide videnced the individual had 3 to provide home health alf of the agency. The file attention of the agency of the competency evaluation and 12/4/13. The same of the following skills were are director of nursing on an of range of motion - active and lower extremities, and lower extremities, and lower extremities, and 12/4/13. The same of the following skills were are and lower extremities, and lower extremities, and lower extremities, and lower extremities, and 12/4/13. The same of the following skills were are and lower extremities, and lower extremit	{G 2 ⁻¹				
assisted with blood pressure monitoring. 3. On 12/17/13 at 12:40 PM, employee A indicated she did not realize the entire competency program had to be completed before the aide independently worked in patient's homes.							

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15K116		B. WING			R		
			B. WING	ет	REET ADDRESS, CITY, STATE, ZIP CODE	12/	17/2013
NAME OF PROVIDER OR SUPPLIER COMFORCARE HOME HEALTH			11	555 NORTH MERIDIAN STREET, SUITE 100 ARMEL, IN 46032			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	D BE COMPLETION	
{G 212}	Continued From page 4		{G 2	12}			
{G 213}	4. The policy titled "Quality Management - Nursing Aide / HHA" stated, "All aide services are provided in accordance with the recognized state regulations Aide Training. The aide must pass a HHA [home health aide] competency exam and a registered nurse will complete a competency assessment skills checklist with direct observation of each skill for each aide before assignment begins." 484.36(b)(2)(i) COMPETENCY EVALUATION & IN-SERVICE TRAI The competency evaluation must address each of the subjects listed in paragraphs (a)(1)(ii) through (xiii) of this section.		{G 213}				
	Based on personnel policy review and interensure home health a competency evaluation all of the required subservices in 1 (file E) or reviewed, the only hor creating the potential patient that received in the policy of the pol	not met as evidenced by: file, clinical record, and erview, the agency failed to aides had completed a on program that addressed oject areas prior to providing of 1 home health aide file me health aide employed, to affect the one current home health aide services.					
	The findings include: 1. Personnel file E evidenced the individual had been hired on 8/12/13 to provide home health aide services on behalf of the agency. The file included an incomplete competency evaluation that was dated 8/12/13 and 12/4/13. The same competency document was continued from						

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER COMFORCARE HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 11555 NORTH MERIDIAN STREET, SUITE 100 CARMEL, IN 46032		12/1//2013		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
{G 213}	8/12/13 and evidence evaluated by the net 12/4/13: 1) Evaluation and passive of upper active and passive, chair, 3) A bed bath a bed, 6) Blood pressespirations, and pure Reporting patient characteristics and prevaluation failed to evaluated for the coskills. 2. Clinical record # included documentate services on Novemble 6 and 11, 2013. Dura assisted with blood 3. On 12/17/13 at 1 indicated she did not competency programe the aide independent homes. 4. The policy titled 'Nursing Aide / HHA' provided in accordance regulations Aide pass a HHA [home leasm and a register competency assess	ded the following skills were we director of nursing on on of range of motion - active or and lower extremities, 2) Positioning in a bed and (a, 4) Nail care, 5) Shampoo in usure, temperature, lise, 7) Infection control, 8) anges and 9) Recognizing occedures. The competency evidence the aide had been impetent performance of all (b, 5), start of care 11/29/13, tion employee E provided over 29, 2013, and December ring these visits the aide pressure monitoring. 2:40 PM, employee A trealize the entire on had to be completed before on the total worked in patient's (c) and the recognized state of the recognized with the recognized state of the recognized state of the recognized state of the recognized with the recognized state of the recognized state of the recognized state of the recognized with the recognized state of the recognized stat	{G 21:					